DeJarnette Center
Primary Inspection

Office of the Inspector General
June, 1999

Executive Summary:

This report summarizes the findings during an extended visit made to DeJarnette Center in late April 1999. This report was submitted to Governor Gilmore and Secretary Claude Allen on June 11, 1999.

Currently there are many forces addressing severe deficiencies in the public funded Mental Health, Mental Retardation and Substance Abuse (MHMRSAS) Facility System in Virginia. The items selected for review in this report were selected based on relevance to current reform activity being undertaken by DeJarnette as well as other facilities throughout Virginia. This report is intentionally focused on those issues that relate most directly to the quality of professional care provided to patients of the facility. It is intended to provide a view into the current functioning of DeJarnette Center.

This report is organized into eight different areas. These are: 1) Treatment of Patients with Dignity and Respect, 2) Use of Seclusion and Restraint, 3) Active Treatment, 4) Treatment Environment, 5) Access to Medical Services, 6) Public-Academic Relationship, 7) Notable Administrative Projects, 8) Facility Challenges. Under each of these areas are one or more "findings" with related background discussion and recommendation.

The following findings constitute a summary and would be taken out of context if interpreted without review of the accompanying background information.

Findings of Merit:

DeJarnette staff places a strong emphasis on the treatment of patients with dignity and respect. (Finding 1.1)

DeJarnette has significantly reduced the use of seclusion and virtually eliminated the use of "mechanical restraint" over the last three years. (Finding 2.1)

DeJarnette staff reports an effective working relationship with current medical coverage. (Finding 5.1)

DeJarnette collaborates with many Colleges and Universities to provide training

opportunities for a number of different professions. (Finding 6.1)

DeJarnette staff is developing a promising Utilization Review project involving projected length of stay for a given diagnosis. (Finding 7.1)

DeJarnette currently engages in a limited satisfaction survey of discharged patients. (Finding 7.3)

Findings of Concern:

DeJarnette has been in the current new building since 1996 AND IT STILL DOES NOT HAVE AN OCCUPANCY PERMIT! (Finding 4.1)

DeJarnette serves a number of children with active substance abuse problems, but offers virtually no substance abuse treatment. (Finding 3.1)

Post seclusion debriefing does not consistently occur following seclusion events. (Finding 2.2)

DeJarnette Nursing Staffing does not meet Department of Justice standards. (Finding 7.2)

Activities and group programming schedules remain generic on DeJarnette Units. (Finding 3.2)

DeJarnette is currently without a permanent facility Director. (Finding 8.1)

DeJarnette is currently without a clearly articulated mission regarding its niche in the spectrum of providers of public and private mental health services to children. (Finding 8.2)

DeJarnette social work and psychology staff is not present on weekends so that they miss opportunities to directly interface with families picking up and returning patients from passes. (Finding 3.3)

Treatment Team members work well together, but time use is not efficient (Finding 3.4)

Many patients complain about the food system in place at DeJarnette. (Finding 4.2)

DeJarnette Report

Date of Visit: April 28-30, 1999

Reason for Inspection: Initial Primary Inspection

Circumstances of Inspection: Essentially Unannounced (note: DeJarnette staff expected only a 3 hour visit, the three day stay was not announced.)

Sources of Information: Interviews with several current inpatients, DeJarnette clinical staff, DeJarnette management staff, and various documents provided prior to and throughout the inspection both by DeJarnette staff and other sources.

Focus of Inspection: General conditions and status of active treatment methods, environment safety, and selected aspects of management practice.

Specific Areas reviewed:

1. Treatment of Patients with Dignity and Respect
2. Use of Seclusion and Restraint
3. Active Treatment
4. Treatment Environment
5. Access to Medical Services
6. Public-Academic Relationships
7. Notable Administrative Projects
8. Facility Challenges

DeJarnette Background

DeJarnette Center began its mission as a specialty child and adolescent treatment center in 1975. Design for the current building began in 1985. This building was occupied in 1996. With the move, the DeJarnette census went from 60 to a 48-bed capacity. DeJarnette is structured such that it has four treatment units of 12 beds each. The units are stratified by general age such that there are two adolescent units, a "pre-teen" unit and a younger child unit. DeJarnette received JCAHO accreditation initially in 1985. The most recent JCAHO survey was in 1997, at which time DeJarnette received "Accreditation with Commendation" in the new site. A summary of Accreditation Information documented only the following: "No recommendations for improvement were identified as a result of the full survey conducted on 2/26/97." DeJarnette is licensed by the Department of Mental Health, Mental Retardation, and Substance abuse services. The Department of Justice (DOJ) has not investigated DeJarnette Center.

Generally DeJarnette is fortunate to have a staff that is very committed to the care of the very difficult children referred to them. DeJarnette is a relatively small facility with few full time administrative staff. Most administrators also have clinical duties. This results in a fairly tight management system that is able to respond fairly quickly to priorities identified and supported by staff. Several of the findings and

recommendations within this report could be accomplished within existing resources.

1. Treating Patients with Dignity and Respect

1.1 Finding: DeJarnette staff places a strong emphasis on the treatment of patients with dignity and respect.

Background: The ability to treat patients with dignity and respect is a vital component to the treatment environment at DeJarnette and all facilities. Throughout the facility numerous emotionally intense encounters with patients and families were observed. Staff of all disciplines was observed to be very respectful of patients. Training of all new staff includes emphasis on treatment with dignity and respect. Facility training staff have modified the emphasis of the prescribed aggression management curricula (MANDT training) to focus on the modeling and use of respect for others as a technique to proactively reduce the need for the use of physical restraint and seclusion.

Recommendation: Rework DeJarnette Center Mission and Values Statement to emphasize the successfully established DeJarnette value regarding treatment of patients with dignity and respect.

2. Use of Seclusion and Restraint

2. 1 Finding: DeJarnette has significantly reduced the use of seclusion and virtually eliminated the use of "mechanical restraint" over the last three years.

Background: DeJarnette policy specifies seclusion as the placement of a child in a room with the door secured such the child can not open it. DeJarnette policy defines two types of restraint: mechanical and physical. Mechanical restraint is the use of a device designed for restraint. Physical restraint is the restriction of movement through application of

MANDT technique. DeJarnette does not use "therapeutic holding" as is done in some child and adolescent programs.

In September 1996, the base rate of seclusion events per 100 patient days was about 9, in September 1997 it had reduced to about 3, and by September 1998 it was about 2. (See enclosed data from DeJarnette.) Mechanical restraint use has virtually been eliminated. With regard to Physical restraint, no trend is readily obvious in the data provided by DeJarnette staff. This data is likely to be very influenced by individual patients; i.e. one patient requiring frequent physical redirection would skew the overall data of a ward significantly.

The internal Advocate at DeJarnette is responsible for the collection of data regarding seclusion and restraint. She has instructed staff to report virtually all restrictive contact with patients as physical restraint. She feels this results in over reporting, but also insists this has sensitized staff to issues of appropriate use of restraint and treatment of patients with dignity. Thus, if a patient holds up a fist in a play or real aggressive gesture, and staff pull the threatening fist down to the patient’s side then release it, this constitutes use of physical restraint and is documented as a restraint event.

While at DeJarnette, several days of "raw data" regarding seclusion and restraint were reviewed. Trends in the time period of April 15 to 29 data show Seclusion which was referred to as Time Out used usually about 10 to 15 minutes. Seclusion referred to as Seclusion was used for longer periods of time, the longest being one hour and 55 minutes. Physical Force Restraint was generally used from 1 to 5 minutes per event. Time out and Physical Force Restraint are reported in DeJarnette data, but not defined in the DeJarnette Seclusion and Restraint Policy. My preference is to use the term "time out" or voluntary seclusion to define a behavior that we encourage patients to use in their community life as a stress and anger management tool. Seclusion should be reserved and identified as an inpatient emergency procedure. The policy, as a "living

document" needs to be consistent with reported data, or provide clarification of variance from it.

The entire facility system, with DMRMHSAS guidance, is developing a standard set of seclusion and restraint policies. DeJarnette will want to make all terms in the central policy and any additional facility policy consistent.

Recommendation: Revise the DeJarnette Center Seclusion and Restraint Policy to make terms consistent with reported Data printouts and new Departmental Policy as it is developed.

2.2 Finding: Post seclusion debriefing does not consistently occur following seclusion events.

Background: Several patients who had been in seclusion were interviewed within 24 hours of the seclusion event. The children had an understanding as to why seclusion was used. They stated they were told what they had to do to get out of seclusion, and understood those requirements. One patient did report that staff did not quickly respond when she requested to use the bathroom while in seclusion. Several charts documenting seclusion events were reviewed. Documentation was adequate and consistent with policy.

The Seclusion and restraint policy includes debriefing with the patient after a seclusion event. Based on patient, staff and administration input, this does not occur consistently. Post seclusion debriefing is an active treatment opportunity that should be capitalized on! Ideally all staff present on the unit at the time of the seclusion event should briefly process with patient and each other the events leading up to the use of seclusion. The debriefing should include a brief recap of events leading to the emergency situation, and skills the patient could have used to avoid seclusion. A focus on what would happen in similar circumstance in the community should be a regular part of the post seclusion debriefing.

Recommendation: Institute mandatory debriefing following each and every seclusion episode.

3. Active Treatment

3.1 Finding: DeJarnette serves a number of children with active substance abuse problems, but offers virtually no substance abuse treatment.

Background: Estimates made by staff indicate that 50 to 70% of the older patients admitted to DeJarnette have problems with active substance abuse or heavy experimentation with drugs. In many situations substance abuse is a mitigating circumstance in the creation of the behaviors and situations that result in admission. It is essential that any existing problem of substance abuse be addressed while patients are at DeJarnette. To overlook or minimize the role of alcohol and drug abuse in this population is tantamount to colluding with the patient that the problem is not really important or worthy of treatment. There are a number of "pre treatment" and treatment models that would be appropriate for the current average length of stay at DeJarnette. Additionally there are several existing adolescent substance abuse treatment programs in the Staunton area that may be able to collaborate or share staff to create a treatment tract for DeJarnette patients. DeJarnette may need additional resources to address this problem, but this is essential.

Recommendation: Add a formal substance abuse treatment component to the program.

3.2 Finding: Activities and group programming schedules remain generic on DeJarnette Units.

Background: The active treatment concept has been a prominent part of the plan of correction for a number of the facilities in Virginia that have come under the scrutiny of the Department of Justice. The Civil Rights for Institutionalized Persons Act (CRIPA) entitles those who are in a state run institution to active treatment. That is, they can not be simply kept out of society and "warehoused" or

medicated. Ideally, active treatment contains components of training, treatment and rehabilitation that enhance the chances of good quality of life in a community or non-institutional setting.

Active treatment at DeJarnette must work around school attendance requirements for school age children. The school classrooms are in a separate part of the building than the living units. Thus the children go from "home" to school during normal school hours. This leaves less time for active treatment programming than a typical adult inpatient schedule. Additionally, school at DeJarnette is an intense experience for the children, with many of them receiving much more attention in much smaller classrooms than they are accustomed to in their regular schools. Overall school seems well received by the children, and this is despite numerous learning disabilities and other behaviors that make experiences in school challenging for many of these children. The current relationship with the school system seems to be working well, although this has not always been the case. School staff are integrated by policy as a part of the treatment team for a child, but have no formal supervisory relationship with DeJarnette administration. (Teachers were not present at the treatment team events that were observed during the inspection, however clinical staff seemed to be in close communication with teaching staff.) It is legitimate to include the school experience as a component of active treatment, but clearly it should not be the role of school to provide primary mental health treatment per se.

The treatment begins with a full diagnostic assessment by social work, nursing, psychology and psychiatry. In addition to assessment services, each ward has a very developed behavior management system with levels keyed to the developmental stage of the population served by that unit. Additionally, the majority of children have individual therapy with a psychologist, group activities and much opportunity for structured leisure skills. They are assessed for appropriateness of psychiatric

medication. Physical problems are addressed on an as needed basis.

Although somewhat institutional, this strong behavioral paradigm does seem to have the effect of promoting cooperation among the children while they are on the unit. Does this type of unit programming which works well for adapting to hospital cultural expectations, have lasting benefits when children return to their community?

Review of ward schedules reveals much of the scheduled activity time reserved for leisure skills, games, leisure education, and social skills. Overall the activity program schedules appear to be geared toward entertainment as opposed to activities that are engineered by staff to address problems that resulted in admission to the hospital or will specifically enhance integration into their communities. Clearly rest and relaxation skills are important, particularly for a group of kids who have had to grow up fast. Much learning and behavior modeling does go on during the type of group and individual activities described.

Most of the adult facilities are currently developing extensive psychosocial rehabilitation programming as a mechanism to provide active treatment. DeJarnette staff may find it useful to review some of the models for treatment activities that other facilities in Virginia are using. DeJarnette is too small and length of stay to short to engage in a comprehensive treatment mall format, however inclusion of psychosocial programming that is facility wide, particularly with scheduling on weekends would be of therapeutic benefit to the patients. This would include topic and skill-building groups geared to the needs of the children present. DeJarnette has motivated and dedicated clinical and activities staff, perhaps they could be challenged to get more creative with activities and clinical programming.

Recommendation: Sharpen the activities and group programming.

3.3 Finding: DeJarnette social work and psychology staff are not present on weekends so that they miss opportunities to directly interface with families picking up and returning patients from passes.

Background: Currently many patients go home or have trial visits with families on the weekend. Successful integration in their families is an essential component of discharge planning for a number of the children. It would be of great service to the children served by DeJarnette, to have professional therapy and social work staff available to meet with families on weekends. Typically many working families or those with other school age children can only come on weekends when family therapy staff and discharge planning staff are not available. This will only become more necessary when the geographic catchment area for DeJarnette increases and number of admissions increases. If given funding for additional professional staff to meet Plan of Correction or identified "CRIPA staffing ratios", have professional staff assigned and available on weekends to meet with families picking up and returning patients from therapeutic passes.

Recommendation: Accommodate family schedules by having professional staff available on weekends.

3.4 Finding: Treatment Team members work well together, but time use is not efficient.

Background: Treatment planning is another component of active treatment that a number of the facilities under investigation by the Department of Justice are focusing on. DeJarnette has a well-developed team process that seems to work with regards to the treatment as it is delivered to the patient on a particular unit. Several initial case staffing (also known as Master Treatment Planning) sessions were observed. Staff did a nice job including parents through phone conferencing technology. Unfortunately, in several of the sessions, the majority of time was spent reading social history and confirming historical details with the parent. This meant that little time was left for

professional summaries of clinical assessments and recommended individualized treatment. In fact, the meetings which were scheduled for one hour, typically ended after 1 to 11/2 hours without a treatment plan actually being constructed. It was as if time was spent getting the individual details correctly, only to plug the patient into a standardized treatment plan. Many staff left the meeting at the time it was scheduled to end, such that only a fragment of the team was present by the time they got around to inviting the patient in.

Staff from "non-Department of justice" facilities have been discouraged from consulting with the DMHMRSAS treatment planning expert, Dr. Nirbhay Singh due to his time constraints. DeJarnette may be able to sharpen the treatment planning process through its own quality improvement process. Sharper treatment planning would increase efficient use of staff time (less time in meetings and more time with patients), and would increase the individual focus in each patient's actual treatment.

Recommendation: Sharpen treatment planning meetings and process.

4. Treatment Environment

4.1 Finding: DeJarnette has been in the current new building since 1996 AND IT STILL DOES NOT HAVE AN OCCUPANCY PERMIT!

Background: The problem is reported to be a fire code violation. If the building catches on fire, the occupants of the building go outside into small courtyards that are locked by a padlock. All staff carries keys to these padlocks. DeJarnette administration has been aware of the problem and was told to move into the building anyway. Reports indicate it would cost about $200,000.00 to rectify this situation.

DeJarnette is constructed on a hill in a field on property adjacent to Western State Hospital. Although there have been several donated trees and

gardening projects, there is no formal landscaping. The interior of the building is clean and well maintained. Overall the building spaces including classroom, gym, administrative offices and treatment units appear adequate in size to meet the treatment mission of the facility. The days of the inspection there was a mechanical problem with the air conditioning. Maintenance and utility costs in the new building have been much higher than originally anticipated.

Recommendation: DeJarnette needs an Occupancy Permit immediately.

4.2 Finding: Many patients complain about the food system in place at DeJarnette.

Background: DeJarnette patients are fed by the ultimate in institutional feeding systems, the Cook-Chill system. This is truly an amazing system wherein food is prepared days in advance on trays and kept chilled in large units (which resemble industrial refrigerators) until it is time to be prepared for a meal. At this point, the same unit heats up the portion of the trays that require heating and they are delivered to patients by direct care staff. DeJarnette employs no food service staff. While the system can accommodate some preferences such as food allergies and diabetic diets, the children do not have the opportunity to choose their own menu. The day the dining room was observed, the menu was a cheese and broccoli-chicken casserole and white rice with a blonde brownie dessert. The hospital human rights advocate states that complaints about this food system are among the most common complaints the children make about the facility. The staff would like to be able to allow the children to have at least a few days where-in they could choose a menu and have some degree of participation in the food they eat. Staff might pursue the possibility of an alternative meal that the children participate in and plan as a unit activity once a week for each unit. Children could select a local carry out restaurant or simple menu and plan, etc. This activity would

develop skills that could be used when the children leave the hospital.

Recommendation: Explore the cost Vs benefit of creating a once a week break from the Cook-chill system for the children on each unit.

5. Access to Medical Services

5.1 Finding: DeJarnette staff report an effective working relationship with current medical coverage.

Background: DeJarnette has access to a pediatrician who has been associated with DeJarnette staff and patients for several years. Staff feel this relationship works well. The Dr. has a local private practice, and visits DeJarnette patients on a regular and as needed basis. The staff feel they also have a good working relationship with the local Emergency Room which is Augusta Medical Center. It has been suggested that an increase in medical staffing to include a nurse practitioner be made. This would allow more ability to coordinate more closely with community or outpatient medical staff and result in improved coordination of medical issues upon admission and discharge of these individuals. Presence of an onsite Nurse Practitioner would be very valuable for these patients. This individual could also provide or coordinate treatment programming along the lines of health maintenance and prevention.

Recommendation: Create a position for on-site Nurse Practitioner.

6. Public-Academic Relationships:

6.1 Finding: DeJarnette collaborates with many Colleges and Universities to provide training opportunities for a number of different professions.

Background: A number of the clinical departments at DeJarnette participate in training activities through various internships. The Recreational therapy staff has an undergraduate program that students from other states have participated in. The

Psychology Department has an active role with University of Virginia psychology interns who regularly spend two days a week at DeJarnette. The University of Virginia Department of Psychiatry sends a resident training in psychiatry to the facility for regular rotations. The experience at DeJarnette is very valued by the residents. At least two of the DeJarnette psychiatrists are on the clinical staff of the psychiatric Department at University of Virginia but their role is more or less limited to volunteer supervisors to residents who are rotating at DeJarnette. It would be beneficial to both DeJarnette and The University of Virginia's Child and Adolescent program to expand the role DeJarnette psychiatrists have within the training program. This could easily occur if psychiatric staffing was expanded as has been suggested by DMHMRSAS consultants. Excellent child psychiatrists are a limited resource, and these psychiatrists could serve as mentors to potential child psychiatrists. This could help Virginia train, recruit and retain child psychiatrists for both community and facility needs throughout the Commonwealth.

Recommendation: Continue to maintain and develop the successful clinical training experiences and internships currently offered at DeJarnette. Strengthen the relationship between the University of Virginia Child and Adolescent Residency Training Program and DeJarnette psychiatrist staff with the goal being creation of a mentoring process that would foster the development of child psychiatrists interested in working in Virginia's Community and/or Facility system.

7. Notable Administrative Activities

7.1 Finding: DeJarnette staff is developing a promising Utilization Review project involving projected length of stay for a given diagnosis.

Background: Staff on the Clinical Review Committee have worked out an average or anticipated length of stay for each of the 49 most common diagnoses treated at the Center. When a

patient stays beyond the usual stay for that diagnosis the case is reviewed by the attending physician and determination made as to the appropriateness of the longer duration of stay. In other words, the patient may be there longer than average due to complicated clinical situation ("continued stay required") or may be there only due to complicated discharge planning ("continued stay not required"). As the facility gains more experience with this program, they will be able to adjust anticipated length of stay, and have some very valuable profiling data for their own internal utilization review. Additionally they will be able to use information to help CSB's with discharge planning. This process resembles a clinical pathway or best practices program akin to what a managed care or private facility might use to help understand costs of care. There is at least one child who has been an inpatient several months in "continued stay not required" status due to discharge problems. DeJarnette staff has made a clear commitment to refuse to discharge a patient to a setting they feel is not likely to work for the child.

Recommendation: Continue to develop the Length of Stay project.

7.2 Finding: DeJarnette Nursing Staffing does not meet Department of Justice standards.

Background: Generally, Department of Justice standards require one RN per unit per shift. Because DeJarnette units are small (12 patients each) and each unit interconnects with one other, DeJarnette feels that one nurse per two interconnected units present on all shifts would be sufficient to meet the intent of Department of Justice Standards. Currently DeJarnette has a situation wherein 30% of the time; night shift has only one nurse for all 48 patients.

DeJarnette nursing staff has a very well developed Continuous Quality Indicator (CQI) program. DeJarnette nursing staff has a RN degree as a minimal requirement. They work in a "professional model of practice" with each nurse participating in the nurse practice committee. This committee

together with the Director of Nursing regulates nursing functions and nursing CQI projects at the hospital. Nursing has a low turnover at less than 4%. There is an unusual relationship with a Clinical Nurse Specialist who is outside the regular nursing supervisory structure.

Recommendation: Establish sufficient Nursing FTE's to meet Department of Justice Intent.

7.3 Finding: DeJarnette currently engages in a limited satisfaction survey of discharged patients.

Background: Two satisfaction survey efforts have been developed at DeJarnette. The current ongoing process is a brief survey given by social work staff to parents or guardian upon discharge. This instrument asks questions regarding parental satisfaction with the treatment process and the opportunities for parents to participate. No tabulated results were available at the time of the request. Exposure to the treatment process evidenced much effort to involve parents in the treatment. If this consumer satisfaction goal has been met, a new issue could be addressed. The second satisfaction process, which contains outcome information, looked at follow up of patients two years following discharge. The last tabulation of this data was presented in 1995 on children discharged in 1992 and 1993. The information collected in this process was so subjective it is essentially useless as a valid outcome report. Additionally it is not clear what DeJarnette staff would or could do with results generated through this instrument. The Department is currently developing a system wide Performance and Outcome Measurement System (POMS) which ultimately may provide useful information to DeJarnette staff. Review of the Departmental Web Page regarding pilot POMS projects does not mention DeJarnette. Given the current level of public concern regarding our facility system, it is prudent for facilities to learn from the experiences of their consumers. Perhaps until POMS produces results that can be of assistance to DeJarnette staff in their ongoing management of services, DeJarnette would benefit from an enhancement of

its consumer satisfaction process. Once POMS is in place, DeJarnette still may have individual satisfaction issues it wants to survey and address.

Recommendation: Enhance the utility of the current user-friendly satisfaction instrument by defining satisfaction endpoints and revising the process once these goals have been met.

8. Facility Challenges

8.1 Finding: DeJarnette is currently without a permanent facility Director.

Background: An acting director, Dr. Donald Roe, currently manages DeJarnette Center. The new director at DeJarnette will be the first to function under the new performance standards as created from recommendations of the Hammond Commission. Administrative and line staff feels comfortable with the direction of Dr. Roe who has worked with DeJarnette for a number of years and has a good working knowledge of the facility.

Recommendation: Pursue a high quality experienced administrator to fill the vital job of facility director at DeJarnette Center.

8.2 Finding: DeJarnette is currently without a clearly articulated mission regarding its niche in the spectrum of providers of public and private mental health services to children.

Background: During the days of the inspection there was discussion and focus on the possibility of closure of adolescent beds at Central State Hospital. Staff were attempting to anticipate the impact on treatment needs. Some anticipated that annual admissions would increase by as many as 300 admissions, changing the number of total annual admissions from about 400 patients to about 700 patients. Assumptions were made that this would also by necessity result in shortened length of stay overall from the current stay of just over 30 days to around 20 days. DeJarnette is a valuable state resource with a dedicated staff who have an established expertise and interest in the patient

population they serve. It would not be in the best interest of the most severely emotionally disturbed children of our commonwealth to have DeJarnette services diluted. We want to preserve and develop them as a center of excellence for problems that other shorter-term private facilities and community systems are not able to manage. If DeJarnette is also expected to provide extensive outreach to communities and other hospitals, this needs to be set out as a clear expectation and resources provided to perform this function.

Recommendation: Articulate clearly the intended role for DeJarnette Center within the Treatment spectrum of public and private providers for Children and Adolescents in the Commonwealth of Virginia. Adopt admission, discharge and outreach policy that mirrors this expectation.